

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01569

01515

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u> 23-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BERLIN NURSING HOME</u>				d. STREET ADDRESS <u>R.F.D. 1</u>			
3. NAME OF DECEASED (Type or print) <u>HARRY ALBERT BRADFORD</u>				4. DATE OF DEATH <u>JAN 17 1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 16, 1882</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMP.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEWARK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WILLIAM BRADFORD</u>				14. MOTHER'S MAIDEN NAME <u>MARY MARTHA LAMK.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>182-03-7679</u>		17. INFORMANT <u>Mrs EDNA L. STAYTON</u> Address <u>OCEAN CITY MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial</u> <u>444X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Senility</u> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>1-17-66</u> <u>BE</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-</u> , 19 <u>66</u> , to <u>1-17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-15-66</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Clifford E. Scholtz</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Clifford E. Scholtz MD</u>	
22d. ADDRESS <u>BERLIN, MD.</u>				22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE <u>John J. Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN MD.</u>	
24. FUNERAL DIRECTOR <u>The Burbage Funeral Home, Berlin Md</u>				25a. DATE <u>JAN 21 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01310

01310

11

11

11

11

11

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01570

01516

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Showell</u>		c. LENGTH OF STAY IN 1b <u>8 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Rural Showell</u> <u>23-1</u>	
3. NAME OF DECEASED (Type or print) <u>John Frederick Brown</u>		4. DATE OF DEATH <u>Jan. 13 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 19, 1910</u> 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer & Engraver Treasury Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Showell Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Brown</u>		14. MOTHER'S MAIDEN NAME <u>Verona Bodley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>World War II 579-12-80</u>		16. SOCIAL SECURITY NO. <u>579-12-80</u>	
17. INFORMANT <u>John MacDonald</u>		Address <u>47 Radnor Blvd Marilton, N.J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging - Self inflicted</u> 974X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mental Depression</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Clifford E. Schott</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Clifford E. Schott, M.D.</u>		22. DATE SIGNED <u>Jan. 15, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 17, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bishopville Md.</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burby</u>		25a. REC'D BY REGISTRAR <u>Berlin</u> 25b. REGISTRAR'S SIGNATURE <u>John MacDonald</u>	
ADDRESS <u>Berlin Md</u>		DATE <u>JAN 21 1966</u>	

01510

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01510

FOR STATE -

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Discernible words include:]

Medical Examiner's Certificate of Death

State of New York

County of ...

City of ...

Decedent's Name ...

Age ...

Sex ...

Color ...

Height ...

Weight ...

Build ...

Occupation ...

Education ...

Marital Status ...

Place of Birth ...

Date of Birth ...

Date of Death ...

Time of Death ...

Place of Death ...

Cause of Death ...

Manner of Death ...

Signature of Medical Examiner ...

Signature of Coroner ...

Signature of ...

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01571

01517

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>R1 Ocean City</u> c. LENGTH OF STAY IN 1b <u>11 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>South Harbor Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>WOR</u> c. CITY OR TOWN (if outside corporate limits; write RURAL and give nearest town) <u>R1 Ocean City 23-1</u> d. STREET ADDRESS <u>South Harbor Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sadie Mae BRUND</u> First Middle Last 4. DATE OF DEATH <u>JAN. 18 1966</u> Month Day Year				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				8. DATE OF BIRTH <u>JAN. 6, 1917</u> 9. AGE (In years last birthday) <u>49</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
11. BIRTHPLACE (State or foreign country) <u>Ocean City, Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>NORRIS Campbell</u> 14. MOTHER'S MAIDEN NAME <u>Stella Simpson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-38-1396</u> 17. INFORMANT <u>Mrs. Sandra Harper, daughter, Ocean City Md</u> Address <u>R1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA BREAST.</u> <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH <u>8 years.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S SIGNATURE <u>F.J. Townsend, Jr MD</u> EXAMINER'S NAME (Type) <u>F.J. Townsend, Jr MD</u> Address (Street, city, town, or county) <u>Ocean City, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>1/21/66</u>		<u>Evergreen</u>		<u>Berlin Md</u>	
24. FUNERAL DIRECTOR <u>Anna A Burbage</u> ADDRESS <u>Berlin Md</u>				25a. REC'D BY REGISTRAR <u>JAN 24 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

0151

0157

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]

[Faint, mostly illegible text at the bottom of the page, likely bleed-through from the reverse side.]

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01572

01518

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Pocomoke</u>				c. LENGTH OF STAY IN 1b <u>23-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. 3</u>				d. STREET ADDRESS <u>R.F.D. 3 Box 68</u>			
3. NAME OF DECEASED (Type or print) <u>Christopher</u> First <u>Church</u> Middle Last				4. DATE OF DEATH <u>Jan. 29</u> Month Day Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 5, 1966</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>19</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Weldon Church</u>				14. MOTHER'S MAIDEN NAME <u>Marie Beckett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Weldon Church R.F.D. 3 Pocomoke, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. OATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7630</u> DUE TO <u>Interstitial Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Exposure to cold</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dan Rafat</u>				M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DANIEL RAFAAT</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22. DATE SIGNED <u>2-3-66</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Armhouse Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Snowhill, Md.</u>	
24. FUNERAL DIRECTOR <u>Samuel George</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
ADDRESS <u>New Church, Va.</u>				DATE <u>Feb 7 1966</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01572

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0151

1911

DAVID CHIT

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS <u>R.F.D. 2, Box 47</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Henry</u> Last <u>Dale</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1900</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Dale</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Hudson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-7895</u>	
17. INFORMANT <u>Ida Mae Dale</u>		Address <u>Snow Hill, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA RT LUNG WITH COMPLETE</u> <u>ATOLECTASIS RT LOWER LOBE</u> (c) <u>4 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RADIATION MYELOPATHY OF SPINAL CORD</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1, 1966</u> to <u>JAN 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>JAN 7, 1966</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert L. Lamar</u>		22b. DATE SIGNED <u>1-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. LAMAR</u>		22d. ADDRESS <u>104 9th St. Snow Hill, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 15, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Meth. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill, Md.</u>	
24. FUNERAL DIRECTOR <u>Samuel Savage</u>		25a. REC'D BY REGISTRAR <u>DATA</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 14 1966</u>	

01310

01310

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City c. LENGTH OF STAY IN 1b 50 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 202 Walnut Street		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City d. STREET ADDRESS 202 Walnut Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANKLIN GOLDSBORO DENNIS First Middle Last		4. DATE OF DEATH January 11 1966 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1892 yrs.
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting Clerk 11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John G. Dennis		14. MOTHER'S MAIDEN NAME Ellen Belle Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WW 1		16. SOCIAL SECURITY NO. 218-05-0590 17. INFORMANT Mrs Myrna Dennis, Pocomoke City, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema, pulmonary (b) Degenerative Heart Disease, arterio-sclerotic (c) Hemiplegia, left. Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 days Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 26, 1965</u>, to <u>Jan. 11, 1966</u>, that (I) (we) last saw the deceased alive on <u>Jan. 11, 1966</u>, and that death occurred at <u>1235 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <i>Charles W. Trader, M.D.</i> M.D.		22b. DATE SIGNED Jan 12, 1966	
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.,		22d. ADDRESS 302 Market St., Pocomoke City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-13-1966	23c. NAME OF CEMETERY Bethany Methodist	23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland
24. FUNERAL DIRECTOR <i>Robert H. Watson</i>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
ADDRESS Pocomoke City, Md		DATE JAN 17 1966	

01520

01520

November

Providence City

20 years

Providence City

1000 Main Street

1000 Main Street

October 17, 1902

January 11, 1903

Male

Oct. 17, 1902

Providence City

Providence City

John D. Bennett

John D. Bennett

See

See

Providence City

Providence City

Providence City

Providence City

Providence City

Providence City

Providence City

Providence City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
01575													
01521													
1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> c. LENGTH OF STAY IN 1b <u>91 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN, RFD 23-1</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SALLIE</u> Middle <u>ANN</u> Last <u>DENNIS</u>						4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>1966</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 3, 1874</u>		9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>NEBITT POWELL</u>						14. MOTHER'S MAIDEN NAME <u>LEAH TIMMONS</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Mrs. Howard Quillen, Seayville Del</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH <u>one day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>61</u> , to <u>Jan 23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 23</u> , 19 <u>66</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>[Signature]</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE</u>				23d. LOCATION (City, town or county) (State) <u>BERLIN MD.</u>					
24. FUNERAL DIRECTOR <u>Anna A. Burbage Berlin Md.</u>						25a. REC'D BY REGISTRAR <u>Jan 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

15210

15210

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01576

01522

1. PLACE OF DEATH e. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Berlin</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R2</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WOR</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Berlin</u> d. STREET ADDRESS <u>R2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Dodson</u> Middle Last 4. DATE OF DEATH <u>JAN 30</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 15, 1891</u> 9. AGE (in years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>	
11. BIRTHPLACE (State or foreign country) <u>Heiskerville, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Dodson</u>		14. MOTHER'S MAIDEN NAME <u>Electa Carlisle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>098-05-1171</u>	
17. INFORMANT <u>MRS. Dodson, wife</u> Address <u>R2 Berlin, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 4201 DUE TO <u>Coronary artery disease, severe.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u>Ocean Park, Md.</u>	
22. DATE SIGNED <u>JAN 31, 66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/2/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town or county) (State) <u>Berlin MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md.</u>		25a. REC'D BY REGISTRAR <u>FFB 4</u> DATE <u>1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

First Name: [illegible] Last Name: [illegible]

Age: 14

Gender: Male

VI

Place of Birth: [illegible]

VO

[illegible text]

X

X

X

[illegible text]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton c. LENGTH OF STAY IN 1b 3 Weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holland Care Home					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY Accomack c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague 83-3 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Kathryn E.			First Middle Last Dukes		4. DATE OF DEATH 1-28-66 19 19						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1889 77 yrs.		9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Peter F. XXXXX Gray					14. MOTHER'S MAIDEN NAME Ella Rickards						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. no #		17. INFORMANT John T. Dukes Chincoteague, Va. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO (c) Gangrene toes								INTERVAL BETWEEN ONSET AND DEATH 2 days 4 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan 2, 1966 to 1-28, 1966 that (I) (we) last saw the deceased alive on 1-28, 1966 and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE DAVID RAFAI					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-29-66				
22c. PHYSICIAN'S NAME (Type) DAVID RAFAI					22d. ADDRESS SNOW HILL MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/1/66		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows		23d. LOCATION (City, town or county) (State) Bishopville, Md.				
24. FUNERAL DIRECTOR John Whaley Silhockville, Md. ADDRESS					25a. REC'D BY REGISTRAR FEB 4 1966		25b. REGISTRAR'S SIGNATURE John Charles Judge				

11523

CERTIFICATE OF DEATH

01877

1-28-66

11523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01578

01524

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> 23-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>408 Oxford St.</u>		d. STREET ADDRESS <u>408 Oxford</u>	
3. NAME OF DECEASED (Type or print) <u>Parker</u> First Middle Last		4. DATE OF DEATH <u>Jan. 31</u> 19 <u>66</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 10, 1875</u> 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Wilford Evans</u> Address <u>Temperanceville, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>433.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GEN. ART. SCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/15, 1964</u> , to <u>1/31, 1966</u> , that (I) (we) last saw the deceased alive on <u>1/31 1966</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Neville A. Baron</u>		22b. DATE SIGNED <u>2/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>NEVILLE A. BARON</u>		22d. ADDRESS <u>Pocomoke, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>2-9-65</u>	<u>St. John's Cem.</u>	<u>Atlantic, Va.</u>
24. FUNERAL DIRECTOR <u>Samuel Lang</u> ADDRESS <u>New Church, Va.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>B 7 1966</u>	
		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01579		01525									
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Pocomoke</u> c. LENGTH OF STAY IN MD. <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.F.D. 2</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Pocomoke</u> d. STREET ADDRESS <u>R.F.D. 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Myra D. Jones</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>30</u> Year <u>1966</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 6, 1965</u>		9. AGE (In years last birthday) <u>6</u> yrs. <u>14</u> months <u>14</u> days <u></u> hours <u></u> min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>Alonzo Holden</u>					14. MOTHER'S MAIDEN NAME <u>Diana Hemmeian</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Diana Hemmeian</u>			Address <u>R.F.D. 2 Pocomoke, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE SUFFOCATION</u> <u>474X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>LARYNGEAL-TRACHEAL BLOCKAGE</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>2-3 HRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> , 19 <u>66</u> , to <u>2/1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/29</u> , 19 <u>66</u> , and that death occurred at <u>2</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Neville A. Baron</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/1/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>NEVILLE A. BARON</u>					22d. ADDRESS <u>POCOMOKE, MD.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-4-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Pocomoke, Md.</u>					
24. FUNERAL DIRECTOR <u>Samuel Savage</u>					ADDRESS <u>New Church, Md.</u>		25a. REC'D BY REGISTRAR <u>James J. Jones</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>		
					DATE <u>FEB 7 1966</u>						

1833

1833

Received of the
Hon. Secy of the Navy
the sum of \$1000
for the purchase of
the ship "Hull"
on the 1st day of
April 1833

Attest
J. M. Smith
Clerk

Alfred A. Baren
Hon. Secy of the Navy
Washington D.C.

Approved
J. M. Smith
Clerk

Witness my hand
this 1st day of
April 1833

Neville A. Baren
Secy of the Navy
Washington D.C.

1833

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01580

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01526

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Elm Street</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City 23-1</u> d. STREET ADDRESS <u>Elm Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ralph Lee Jones</u> First Middle Last				4. DATE OF DEATH <u>Jan 23 1966</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 2, 1907</u> last birthday	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Law Enforcement</u>		11. BIRTHPLACE (State or foreign country) <u>Whaleyville</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Alec Jones</u>				14. MOTHER'S MAIDEN NAME <u>Ida Downes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>221-09-2822</u>		17. INFORMANT <u>Mrs. Ralph Jones</u> Address <u>Ocean City</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO <input checked="" type="checkbox"/> (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Heart condition</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Clifford E. Schott</u> EXAMINER'S NAME (Type) <u>Clifford E. Schott, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting Address (Street, city, town, or county) <u>Worcester</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-26-66</u>				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Dale Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Whaleyville Md.</u>							
24. FUNERAL DIRECTOR <u>A. Burbage</u> ADDRESS <u>Berlin Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>2 1966</u>			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH e. COUNTY <u>Worcester</u> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Pocomoke</u> g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Pocomoke</u> d. STREET ADDRESS <u>R.F.D. 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Lane</u> Middle Last				4. DATE OF DEATH <u>Jan. 28, 1966</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Mar. 10, 1893</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u> 11. BIRTHPLACE (State or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Lloyd Lane</u> 14. MOTHER'S MAIDEN NAME <u>Emma Jester</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>218-34-7781</u> 17. INFORMANT <u>Estelle Babbs</u> Address <u>2848 Garnet St. Phila., Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>? Acute myocardial infarction</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Heart disease</u> DUE TO (c) <u>? Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>David Rafat</u> EXAMINER'S NAME (Type) <u>DAVID RAFAT</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-29-66</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>2-5-66</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Hall's Hill Cem.</u> 22d. LOCATION (City, town, or county) <u>Pocomoke City, Md.</u>				23. FUNERAL DIRECTOR <u>Edgar Wharton</u> ADDRESS <u>New Church, Va.</u> 24a. REC'D BY REGISTRAR <u>FEB 7 1966</u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

MEDICAL CERTIFICATION

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01582

CERTIFICATE OF DEATH

01528

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. LENGTH OF STAY IN 1b 18 months			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12th Street				d. STREET ADDRESS 12th Street			
3. NAME OF DECEASED (Type or print) BILLY JOE LEWIS				4. DATE OF DEATH Month January Day 3 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 10, 1928	
9. AGE (In years last birthday) 37 yrs.		10. BIRTHPLACE (County & State, or foreign country) Accomack County, Virginia		11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME Burleigh C. Lewis				14. MOTHER'S MAIDEN NAME Ada Bonneville			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Mrs Miriam O. Lewis, Pocomoke, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 164X DUE TO (b) Carcinoma of lung Primary An Post metastatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ?				INTERVAL BETWEEN ONSET AND DEATH 1-2 days 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this, hospital) attended the deceased from March 6, 1965 , to 3 Jan; 1966 , that (I) (we) last saw the deceased alive on 3 Jan 1966 , and that death occurred at 11:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE N.E. Sartorius, Jr.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) N.E. Sartorius, Jr., M.D.	
22d. ADDRESS 114 Market St., Pocomoke City, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-6-1966		23c. NAME OF CEMETERY Belle Haven Cemetery		23d. LOCATION (City, town or county) (State) Belle Haven, Virginia	
24. FUNERAL DIRECTOR Robert H. Watson				25a. REC'D BY REGISTRAR JAN 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

01528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> 1 M 01583 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop c. LENGTH OF STAY IN 1b 5 Months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) XX					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selbyville 46-3 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) ANNIE E. MAGEE First Middle Last			4. DATE OF DEATH Jan. 6, 1966 Month Day Year								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH Oct. 29, 1876		9. AGE (In years last birthday) 89 yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Delaware							
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Peter Bunting								
14. MOTHER'S MAIDEN NAME Laura Hudson			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX (If yes give war or dates of service) XX								
16. SOCIAL SECURITY NO. 222-14-28265			17. INFORMANT Mrs. John Murray Selbyville, Del. Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431X acute myocarditis DUE TO Senility (b) Senility DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) Selbyville		20g. (County) Del.		20h. (State) Del.							
21. I certify that (I) (this hospital) attended the deceased from 2/27/65 to 1/6/66 , that (I) (we) last saw the deceased alive on 12/28/65 and that death occurred at 11:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Clifford E. Schott					22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTT M.D.					22d. ADDRESS BERLIN, M.D.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/9/66		23c. NAME OF CEMETERY OR CREMATORY Red Men							
23d. LOCATION (City, town or county) Selbyville, Del.		23e. (State) Del.		23f. (Country)							
24. FUNERAL DIRECTOR Peter Whaley Selbyville, Del.		25a. REC'D BY REGISTRAR JAN 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION

11525

11525

RECEIVED

11525-11525

11525-11525

11525-11525

11525

11525-11525

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01584

CERTIFICATE OF DEATH

01530

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		c. LENGTH OF STAY IN 1b 23-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 519 S. Church St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Alfred G. McAllister		4. DATE OF DEATH Month Day Year January 28 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1875
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Truck Farm	
11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph F. McAllister		14. MOTHER'S MAIDEN NAME Julia Briddell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ethel M. Perdue, Snow Hill, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Acute Myocardial infarction (c) Atherosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH Few Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 63 , to Jan , 19 66 that (I) (we) last saw the deceased alive on Jan 19 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE David Rafat		22b. DATE SIGNED 1-29-66	
22c. PHYSICIAN'S NAME (Type) DAVID RAFAT		22d. ADDRESS Snow Hill Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-3 1-66	
23c. NAME OF CEMETERY OR CREMATORY Bates Methodist		23d. LOCATION (City or Town) (County) (State) Snow Hill, Maryland	
24. FUNERAL DIRECTOR Charles Judge		ADDRESS Snow Hill, Maryland	
25a. REC'D BY REGISTRAR FEB 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

15510

2614

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01585 CERTIFICATE OF DEATH 01581											
1. PLACE OF DEATH a. COUNTY WORCESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN d. STREET ADDRESS FRANKLIN AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last BELLE W. MITCHELL						4. DATE OF DEATH Month Day Year JAN. 10 1966					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 28, 1872		9. AGE (in years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) PHILADELPHIA PA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN SHARA						14. MOTHER'S MAIDEN NAME ANNIE (?)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Address MR. MORRIS MITCHELL RFD BERLIN MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Age & Senility INTERVAL BETWEEN ONSET AND DEATH 10 min											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-10- , 1966, to 1-10- , 1966, that (I) (we) last saw the deceased alive on 1-10- , 1966, and that death occurred at 8:45 AM , from the causes and on the date stated above.											
22a. SIGNATURE Chas R. Law						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 1-10-1966		
22c. PHYSICIAN'S NAME (Type) Berlin Md.						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/12/66		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN			23d. LOCATION (City, town or county) (State) BERLIN MD.				
24. FUNERAL DIRECTOR Anna A. Burbage						ADDRESS Berlin Md.		25a. REC'D BY REGISTRAR DATE JAN 13 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

18310

33330

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01586

01532

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Snow Hill c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Snow Hill d. STREET ADDRESS 23-1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Gordon		First J.		Middle Nock		Last Nock		4. DATE OF DEATH Month January Day 30 Year 19 66	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1906		9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Truck Farm		11. BIRTHPLACE (State or foreign country) Snow Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gordon E. Nock				14. MOTHER'S MAIDEN NAME Sarah Hatter					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217360574		17. INFORMANT Ruth B. Nock, Snow Hill, Maryland Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Acute Coronary Occlusion Arterial Stenosis Rheumatic Heart Disease								INTERVAL BETWEEN ONSET AND DEATH Few Minutes 10 yrs ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE David R. RAEAT				M.D. DAVID RAEAT				22. DATE SIGNED 2-1-66	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/66		23c. NAME OF CEMETERY OR CREMATORY Bowen Methodist		23d. LOCATION (City, town or county) (State) Newark, Maryland			
24. FUNERAL DIRECTOR [Signature]				ADDRESS Snow Hill, Maryland		25a. REC'D BY REGISTRAR FEB 7 1966		25b. REGISTRAR'S SIGNATURE [Signature]	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01587

01533

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>WOR.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Ocean City</u>				c. LENGTH OF STAY IN 1b <u>55 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt -</u>				d. STREET ADDRESS <u>R - 1</u>			
3. NAME OF DECEASED (Type or print) <u>ANNIE ELLEN PARSONS</u>				4. DATE OF DEATH <u>JAN 8 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 15 1880</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Melton, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JACOB CARMINC</u>				14. MOTHER'S MAIDEN NAME <u>MATILDA JANE LOWE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>D.F. PARSONS (son)</u> Address <u>Rt Ocean City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD with coronary sclerosis</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>57 years</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <u>JAN 8, 66</u>			
ACTUAL SIGNATURE <u>F.S. Townsend, Jr</u>				EXAMINER'S NAME (Type) <u>F.S. TOWNSEND, JR</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>1/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONSBURG</u>	
23d. LOCATION (City, town or county) (State) <u>PARSONSBURG MD</u>							
24. FUNERAL DIRECTOR <u>Anna A. Buehage Berlin Md</u>				25a. REC'D BY REGISTRAR <u>JAN 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01583

RECORDS SECTION, U.S. DEPARTMENT OF AGRICULTURE

01583

U.S. DEPARTMENT OF AGRICULTURE
RECORDS SECTION

[Faint, mostly illegible text covering the main body of the document, likely a letter or report. Some words like "SIR", "PLEASE", and "VERY" are faintly visible.]

FOR STATE
HEALTH DEPT.

01588

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01534

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WOR</u>		
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ocean City</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ocean City 23-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Keyser Pt Road + Route 50</u>			d. STREET ADDRESS <u>R1</u>		
3. NAME OF DECEASED (Type or print) <u>Eda</u> First <u>Cropper</u> Middle <u>Parsons</u> Last			4. DATE OF DEATH <u>JAN</u> Month <u>24</u> Day <u>1966</u> Year		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3, 1903</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife + Motel owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rental</u>	11. BIRTHPLACE (State or foreign country) <u>Rural Berlin, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Mott Cropper</u>			14. MOTHER'S MAIDEN NAME <u>Minnie K. Mitchell</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>218 34 7545</u>		
17. INFORMANT <u>Mrs. Melvin Parker (sister)</u> Address <u>Ocean City, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture, Skull, Massive</u> 825.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Auto accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. (City or town) <u>R1 Ocean City</u> (County) <u>WOR</u> (State) <u>MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>F. S. Townsend, Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>JAN 26, 1966</u>	
EXAMINER'S NAME (Type) <u>F. S. Townsend, Jr.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (street, city, town, or county) <u>Ocean City, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	23d. LOCATION (City, town or county) (State) <u>BERLIN MD.</u>		
24. FUNERAL DIRECTOR <u>Anna A. Burbage</u> Address <u>Berlin Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11534

MEDICAL EXAMINER'S CERTIFICATE OF STATE

01588

IN STATE

STATE OF NEW YORK

1900

EX-100

1900

ADJ. CLERK

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 18&21 Film G373 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01589

01535

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WOR</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Berlin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Berlin</u>		
c. LENGTH OF STAY in 1b <u>Weeks - 6</u>		d. STREET ADDRESS <u>R 2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Andrea Maria Purvell</u>		4. DATE OF DEATH <u>JAN 28 1966</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 Dec 1965</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Willie Rubel Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Emily Viola Purvell</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT <u>E.U. Purvell (Mother)</u>		Address <u>R 2 Berlin, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PENDING / Autopsy</u> 491X DUE TO <u>Pneumonia, bronchial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Nausea & vomiting for 2 days during week preceding death.</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>F.J. Townsend, Jr.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>F.J. Townsend, Jr.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-2-66</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Wardtown Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Pocomoke City, Md.</u>		
24. FUNERAL DIRECTOR <u>Samuel Lowe</u>		25a. REC'D BY REGISTRAR <u>B 7</u> 1966		
ADDRESS <u>New Church, Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

01500

CONTRIBUTION OF HEALTH

01500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01591

Item #1d Film #0375 2/14/66

CERTIFICATE OF DEATH

01537

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN 23-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #3</u>				d. STREET ADDRESS <u>R.F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLIE F. WAINRIGHT</u>		First Middle Last		4. DATE OF DEATH <u>JAN. 31 1966</u>		Day Year	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 7, 1901</u> <u>64</u> yrs.	
9. AGE (In years last birthday) <u>64</u>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMP.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>	
13. FATHER'S NAME <u>GEORGE T. WAINRIGHT</u>				14. MOTHER'S MAIDEN NAME <u>ADD MITCHELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-20-5035</u>		17. INFORMANT <u>Mrs. C.F. WAINRIGHT</u> <u>BERLIN MD</u> <u>R.F.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Car coming off bridge.</u> <u>1539</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>"</u> DUE TO (c) <u>Intestine</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-65</u> , 19 <u>65</u> , to <u>1-31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-26</u> , 19 <u>66</u> , and that death occurred <u>2:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Clifford E. Schott</u> M.D.						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT MD</u>						22d. ADDRESS <u>BERLIN, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burbage</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Berlin Md</u>				DATE <u>FEB 7 1966</u>			

015310

THE JOURNAL OF THE

015310

(M)

RECEIVED FEB 7 1958

CERTIFICATE OF DEATH

Reg. Dist. No.

01538

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City Md				c. LENGTH OF STAY IN 1b 6 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Belden Restorium				e. STREET ADDRESS Main Rd			
3. NAME OF DECEASED (Type or print) First Eugene Middle Brown Webster Last Webster				4. DATE OF DEATH Month Jan Day 13 Year 1966			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-1882		9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Merchant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Zack Webster				14. MOTHER'S MAIDEN NAME Emily Jane Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Louise Andrews Address Deal Island, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerosis Severe, generalized & DUE TO (c) Arteriosclerosis & Coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH minutes years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rt. Indirect Inguinal Hernia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 August 1965 to 13 Jan 66 , that I last saw the deceased alive on 17 Dec 1965 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1-13-66 DATE SIGNED N.E. Sartorius, Jr. M.D. 114 Market St., Pocomoke City, Md. 21851							
ACTUAL SIGNATURE N.E. Sartorius, Jr.				PHYSICIAN'S NAME (Type) N.E. Sartorius, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1-15-66		22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		22d. LOCATION (City, town, or county) (State) Deal Island MD	
23. FUNERAL DIRECTOR'S SIGNATURE Leroy Webster ADDRESS Princess Anne MD				24a. REC'D BY REGISTRAR Jan 19 1966		24b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 of 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

•

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01593		Item #1d Film #0373 2/11/66 pp		01539	
1. PLACE OF DEATH a. COUNTY <u>Worcester</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. LENGTH OF STAY IN 1b <u>All Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>408 Dighton Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henrietta Augusta West</u>		4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1966</u>		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 14 1880</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School teacher</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Worcester</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Bayer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>Mrs. Michael Blue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE INTES TINAL OBSTRUCTION</u> 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ADENOCARCINOMA OF COLON</u> DUE TO (c) <u>1 YR</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u>63</u> , to <u>1-27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-22-66</u> , 19 <u>66</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Robert C. LaMar</u>		22b. DATE SIGNED <u>1-27-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert C. LaMar, M. D.</u>	
22d. ADDRESS <u>104 Bay, Snow Hill Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>2-1-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Phonixer Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill, Md.</u>	
24. FUNERAL DIRECTOR <u>Conita B. Jolley-Jersey, El. Salis, Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01534

01535

Worcester Maryland

Worcester

Snow Hill Md

Snow Hill

all 1.75

408 Dighton St.

Henrietta Augusta West

Female Negro

Mar 14 1880 82

U.S.P.

Retired Soldier Worcester

Local Agent

Unknown

Mr. William B. 1812 Front St. Phila.

Branch 2-1-14
James R. Jolly - Agent, John M.

Branch 2-1-14
James R. Jolly - Agent, John M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH e. COUNTY WORCESTER b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BERLIN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. # 2						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BERLIN Md 23-1 d. STREET ADDRESS Rt. # 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Raymond S Wilson			4. DATE OF DEATH JAN 18 1966			5. SEX MALE			6. COLOR OR RACE W		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH APR. 3 - 1898			9. AGE (In years last birthday) 67 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic			10b. KIND OF BUSINESS OR INDUSTRY SHOP OWNER			11. BIRTHPLACE (County & State, or foreign country) VINCENTOWN BURL. N.J.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Wilson						14. MOTHER'S MAIDEN NAME ANNA Clevenger					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. 145-10-3915			17. INFORMANT Mrs. Robt. Peters			18. ADDRESS 48 JARVIS ST. PEMBERTON, N.J.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis 443X DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (b) 24y Pertussis (c) 24y Pertussis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1-1-66 to 1-18-66 , that (I) (we) last saw the deceased alive on 1-17-66 , and that death occurred 1-18-66 at 11:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Clifford E Schott M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 1-19-1966		
22c. PHYSICIAN'S NAME (Type) CLIFFORD E SCHOTT						22d. ADDRESS BERLIN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 1-21-1966			23c. NAME OF CEMETERY OR CREMATORY Odd Fellow's Cem.			23d. LOCATION (City, town or county) (State) Pemberton, N.J.		
24. FUNERAL DIRECTOR'S SIGNATURE George C. Hall ADDRESS SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR JAN 21 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		

4230